MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Wednesday, March 22, 2006
9:00 AM
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services met on Wednesday, March 22, 2006, at 9:00 A.M. in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair, Senators Austin Allran, Charlie Dannelly, Jeanne Lucas, Vernon Malone, and William Purcell and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Carolyn Justice, and Fred Steen. Advisory members, Senator Larry Shaw and Representative Earline Parmon were present. Senator John Snow also attended the meeting.

Kory Goldsmith, Lisa Hollowell, Ben Popkin, Shawn Parker and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order, welcoming members and guests. She asked for a motion to approve the minutes from the February 16th meeting. Senator Allran made the motion and the minutes were approved.

Representative Insko informed members that staff had prepared a packet of information in response to questions asked by the committee at the last LOC meeting. (See Attachment No. 2)

Carol Shaw from the General Assembly Fiscal Research Division gave a presentation on Medicaid eligibility. (See Attachment No. 3) She explained that the two determining factors to meet Medicaid eligibility are: (1) an individual or family must meet the criteria for one of the categories of eligibility such as being a child, a pregnant woman, aged (over 65) or disabled, and (2) an individual or family must also meet the income and asset requirements that apply for each category of eligibility. Ms. Shaw explained the federal laws addressing mandatory and optional groups and who is eligible under each group. She said that once a person qualifies for one of the categories, they must then meet the income eligibility.

Members asked if a person had to be a citizen or legal resident to receive Medicaid. Ms. Shaw answered that federal law requires a person to be a citizen of the United States and states must document citizenship. North Carolina requires the county Departments of Social Services to receive 2 proofs that someone is a resident of the State. Federal law requires that emergency services be provided to an illegal alien who goes to an Emergency Room and is pregnant and in labor or is an accident victim. Members were

told that staff would look at the exact definition of residency. Ms. Shaw explained the general criteria for those who are not eligible for Medicaid. She developed cases to show examples of those that do not qualify for Medicaid because they do not fit the criteria.

Committee members responded that the State needed to fund services for those who are not Medicaid eligible. Members questioned how much money would be needed. Senator Nesbitt noted that he obtained information last year from Senator Basnight's office that indicated that $500 million would be needed to fund all the waiting lists and all the ineligibles. A report distributed to members produced by the NC Psychiatric Association indicated that there was a short fall for mental health services of about $285 million based on per-capita spending nationally. (See Attachment No. 4)

Lisa Hollowell, Fiscal Research Division, reported on the current MHDDSAS budget. (See Attachment No. 5) She first reviewed the 2-year historical budget information for the Division of MHDDSAS and the authorized budget of the current year. The total budget included State and Federal funds of which Block Grants and Medicaid were included. Medicaid funds support institutions and other services. She explained that her information did not include Medicaid claims and claims amounts to providers and to LMEs being handled by DMA. Ms. Hollowell reviewed the total expenditures and actual receipts for 2005. Almost all receipts are either Medicaid or Block grant funds. She then explained the claims paid by disability for 2005 from the State/Integrated Payment and Reporting System (IPRS) and Medicaid funds. IPRS include State dollars and Block Grant funds paid through the Division to serve the non-Medicaid eligible indigent population. Figures do not include prescription drugs and individuals who appear to not qualify for the target population under Medicaid. In reviewing the average State funds and Medicaid funds spent on each disability, per individual for 2005, it was noted that substance abuse received the least amount of dollars. When questioned about the cost of a CAP slot at $42,000, she explained that the Waiver program provides community-based services to individuals who would otherwise go to an ICF-MR facility with a cost in excess of $85,000 per year. She added that the Federal government recently approved the addition of 2,000 slots which will bring the total to 8,500. However, the State budget limits the number of individuals who can be served.

Ms. Hollowell then defined the target populations in each of the disability groups and the types of services available to those persons. It was noted that confusion remained in the system as to who might be eligible to receive services and who is not eligible. Concern was expressed that all who needed help should be provided care and funding was needed in order for the LMEs to provide services for those who slipped through the cracks. The Division was asked if the target population definitions were appropriate and current. Leza Wainwright, Deputy Director of the Division of MHDDSAS, said there were changes that were proposed for June 1, 2006. It was suggested that staff look at other states to see how they spend their money compared to North Carolina. It was noted that the report by the Psychiatric Association contained information regarding what other states spend compared to what North Carolina spends based on per capita income.

Ms. Hollowell then explained the method and assumptions she used in calculating an estimation of need for additional funding in North Carolina. The estimated number of adults and children meeting the target population for mental health is 557,103; of those 207, 988 were served in 2005. Additional funds needed to serve 11,142 new individuals seeking service in the target population would be $11,153,142 based on the average of state funds spent in 2005. That same number of individuals based on the average Medicaid cost would be $50,216,994. She then reviewed the service need estimate for the developmentally disabled. The estimated number of individuals meeting the target population for developmental disabilities is 134,937 with 36,393 served in 2005. 22,979 of those individuals are eligible for Medicaid costing $488.5 million in expenditures. Additional funds needed to serve 5,745 new individuals seeking services based on the State average of $10,192 per individual would be $58,553,040. Based on the Medicaid average the cost would be $162,847,770. For substance abuse, the total number of people meeting the target population is 429,118 of which 41,640 were served in 2005 and 47,094 individuals were eligible for Medicaid. The estimated number of new individuals to be covered by State funds would be 100, 077 with a cost of $102,879,156. Based on the Medicaid average the cost would be $214,565,088. The total range of State dollars needed based on figures from 2005 for new individuals, would be $172,585,338 to $427,629,852 spent through the Medicaid program. Ms. Hollowell said these estimates only covered the target population, in the public arena, and non-Medicaid eligible but needing services. If all the Medicaid eligibles were served the total would be $800 million, with one-third being State dollars. It was emphasized once again that the system requires an individual to have a severe problem before they can be in the target population. Additional dollars in the system could allow more individuals to enter the target population. Members requested additional information on the number of individuals not in the target population seeking services in all three-disability groups.

Next, Ms. Hollowell explained a chart showing 2005 year-end service data. (See Attachment No. 6) The chart listed each LME, the total population served, the year-end budget and expenditures, service dollar allocation per capita, and the average spent on services per client. Members requested a chart showing the administrative funds. It was noted that the service dollar allocation per capita ranged from $26 to $68 once again emphasizing the inequitable distribution of service dollars.

Continuing, Ms. Hollowell reviewed four different LMEs showing the 2005 average expenditures per client. She said the chart showed State dollars only. Members were interested in seeing the amount of money contributed by the counties as well. Staff was asked to compile the information for the committee.

Ms. Hollowell then gave an update on State Psychiatric hospital downsizing. She began by reviewing the provisions of law showing the direction the General Assembly provided regarding savings, and recurring and non-recurring savings that are generated from the closure of beds. She then reviewed the annual recurring savings stating the total amount of savings that have occurred from the closure of State psychiatric beds was $22 million of which $13.3 million was transferred to the community. She then passed out a chart created by the Division that tracks each facility involved in downsizing showing the

recurring amounts broken down by receipts and State appropriations. (See Attachment No. 7) Phillip Hoffman clarified that because of the consolidation of Dix and Umstead, the recurring savings realized by the downsizing of those institutions is going to the debt service on the new hospital. Recurring savings from the downsizing of Cherry and Broughton goes to the community. Mr. Mike Moseley, Director of MHDDSAS, answered concerns regarding housing for short-term admissions. He said that because those individuals were only there 7 days or less it was very difficult to find adequate conditions to which to discharge patients. Long-term admissions were more readily tracked due to adequate pre-planning. Members suggested that they would like to see the numbers showing how many individuals are discharged to after 7 days to less stable locations and how many are discharged after 30 days to more stable locations. This information would give the committee a target to determine how much housing is needed.

Ms. Hollowell then explained the rising acute care admissions in the State hospitals. She said that substance abuse was the most common diagnoses for those admitted. The lack of community services along with other factors have contributed to the increase in acute admissions. She then gave a brief summary of the State psychiatric hospitals listing the number of patients served for 2004-2005, the number of positions needed to operate the hospitals and the budget for each of the hospitals. Members asked how many beds were in operation at Broughton Hospital. Mr. Moseley responded that for the daily average population there is about 300 beds.

Next, Ms. Hollowell reviewed the use of new funds for fiscal year 2006. She explained how the Division allocated $2 million appropriated through the 2005 Budget Bill for crisis intervention services. Eight LMEs have been selected by the Division to receive these funds because they demonstrated the greatest potential for reducing or diverting hospital admissions and developing local crisis services and capacity. She then showed a listing of the LMEs that received an allocation of $1.5 million for Long-Term Vocational Support Services and listed the LMEs selected to receive $1,250,000 for Intensive Substance Abuse Services for children. The funds cover the start-up and recurring costs for one new program in the area of the LME. Ms. Hollowell added that because not all of the LMEs received funding, this led to further inequity of funding. She referred members to a chart showing the LMEs selected to receive $750,000 for Adult Substance Abuse services.

Senator Nesbitt then reviewed the report from the NC Psychiatric Association saying the report, based on the national average, only covers the expenditures of those with mental illness. (See Attachment No. 4) In order to meet 88.8% of the per capita national average State spending for 2002-2003, North Carolina would need to appropriate an additional $285.5 million for mental health alone. By comparison, Ms. Hollowell's figures were considerably less because they were not based on funding at the national average, but were based on projected unmet needs.

After a lunch break, Representative Insko asked Kory Goldsmith to come forward to give a review of the special provisions regarding various studies the Division had been directed to undertake. (See Attachment No. 8) In 2004, the General Assembly directed

DHHS to study the financing of the MHDDSAS system. That report was due July 1, 2005. The report was not submitted and the Department requested an extension until March 1, 2006. With the permission of the General Assembly, the Division used some of the money from the Mental Health Trust Fund to hire a consultant. She noted the Division would not give that report at this meeting, but rather an update on the progress of obtaining that report. In 2005, the General Assembly also directed the Department to develop a long-range plan for addressing the needs of the MHDDSAS system. The Division used funds from the Mental Health Trust Fund to hire consultants for the report. Ms. Goldsmith said the report was due March 1, 2006, but it was not ready so the Division would give an update on the status of the study.

Phillip Hoffman, Chief of Resource/Regulatory Management for the Division told members of the committee that he apologized for the delay of the Finance Study report. (See Attachment No. 9) Bringing members up to date, he said that the RFP for that study closed on March 21st. An evaluation committee will review the two bids received and a vendor will be selected. The RFP included three products to be delivered. First, the vendor will be asked to include recommendations on the reallocation of existing resources in line with what the legislation requires based on need and not historical funding patterns. This will be delivered in June 2006. Items to be factored in were the counties ability to fund services, the impact of downsizing, and the estimated population growth. He indicated that the recommendation might include a phase-in and the projected dates. Another consideration, according to legislation, was to study the entire funding system for MHDDSA services including Medicaid. He said that this aspect was much more complex than just looking at the existing resources. Mr. Hoffman said that part of the RFP allows the vendor to propose waivers for Medicaid services and to look at all sources of funds going into the public MHDDSA system. This deliverable would be due in November 2006. The third product would be the development of a cost model driven by different variables. This item was required for the vendor to bid on, but is optional for the State to elect to purchase. If the Division elects to contract this product, the final cost model would be due November 2006. Senator Nesbitt reminded members that the report on funding allocations was originally due in 2001, but was never done. He noted that two years ago the Department was directed by the LOC to provide a study. The Department asked for an extension until March 2006. Another extension was requested for August 2006 but that request was denied. The Committee was told that it was now their responsibility to act since the Department will not provide the information.

Next, Steve Hairston, Chief of Operations Support with the Division addressed service gaps and the Long Term Plan for meeting MHDDSA service needs. (See Attachment No. 10) Mr. Hairston said the Department and the Division released an RFP with a request for the elements to be addressed that were in the special provision, along with special attention to crisis services. Christiana Thompson, with Heart of the Matter was selected as the vendor. He then reviewed the eight deliverables within the RFP to be completed between February and June 2006. He said the final report would be submitted June 30, 2006. The Committee again expressed their displeasure with the timing of the report, indicating that the report was too late to be of help with the upcoming budget process.

Leza Wainwright gave an update on regional Utilization Review and Screening, Triage and Referral (UR/STR). She gave a brief history stating that in December Secretary Hooker Odom requested LMEs to form alliances to perform UR functions for Medicaid and State funded services. Eighteen LMEs submitted applications to perform UR functions. It was determined that there were deficiencies in the applications so the Secretary gave the LMEs the opportunity to resubmit their applications. A review team was formed to review the applications and it was determined that none on the applications had met the required standards. Therefore, effective June 1, 2006, the current Medicaid contractor doing UR for MHDDSA services and previously selected through an RFP process (Value Options) will be responsible for doing all Medicaid UR functions with the exception of the five counties that comprise the Piedmont catchment area because they operate under a separate Medicaid waiver. She said that Value Options met all the requirements and the total cost was less than what the State would pay the LMEs to perform the service. Because of the strong concerns from the LMEs regarding regionalizing UR for State dollars, the Secretary directed the Division to develop a technical assistance team to work with the LMEs to develop authorization guidelines for State funded services. Members were interested in knowing how long the contract was with Value Options, the cost, and if it could be changed. Ms. Wainwright said that DMA contracted for three years. She also said the Secretary did not plan to revisit the issue. Members suggested that the LMEs begin training now to take responsibility for UR within the next three years. Ms. Wainwright said she would get the cost figure and that the funds came from DMA and Medicaid budgets. She said the cost model to the LMEs would be revisited to see what the cost of services provided by the LMEs should be. She was told to provide the information to the Committee within the next week. Staff was asked to see if changes could be made to the contract.

The review committee identified five LMEs to perform regional after hours STR. There were some partnerships where a program was not identified as having the capacity to perform the function so the decision as to how to perform the after hours STR in those catchment areas will be determined at a later date.

There being no further business, the meeting adjourned at 2:35 PM.

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Senator Martin Nesbitt, Co-Chair Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant